2018-2019 Annual Enrollment Extra-Help Benefits Guide

County of Sonoma

COUNTY OF SONOMA
ANNUAL ENROLLMENT FOR
ELIGIBLE EXTRA-HELP EMPLOYEES

Monday, March 12, 2018 through Friday, March 30, 2018

Effective date of coverage is June 1, 2018

New Premiums Begin on May 2, 2018 to Pay for June Premiums

Tips

- Review important changes in What's New For 2018-2019
- Check important dates and Annual Enrollment meeting locations
- Contact CareCounsel at (888) 227-3334 if you have any questions on health plan benefits or need help choosing a plan
- Enroll or make changes using Employee Self-Service at https://selfservice.sonomacounty.ca.gov/selfService/action.login Step-by-Step instructions
- Select the right coverage level. Review the medical plan comparison charts
- You need to take action during the Annual Enrollment Period only if you need to make a change; otherwise your current elections will roll over for the new plan year
- Don't delay — enroll or make your changes on or before March 30, 2018
- Detailed benefit plan information and more can be found in this Benefits Guide or online at: http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/

This Benefits Guide gives you an overview of your benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents. For information about your other County benefits, please go to http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/.

In the case of conflict between the information presented in this Benefits Guide and the official plan document, the plan document determines the coverage.

TABLE OF CONTENTS

Contents

AS YOU ENROLL

You are receiving this information because you meet the eligibility requirements to enroll in County medical coverage during the County's Annual Enrollment. If you do not enroll during this annual enrollment period, you will be declining coverage for June 1, 2017 through May 31, 2018.

This Benefits Guide is designed to help you make informed decisions regarding your benefit elections during the 2018 Annual Enrollment Period. It highlights your options and key program features to consider before making enrollment elections. Your benefit eligibility is determined by the terms of your applicable Memorandum of Understanding or Salary Resolution. You will also find in this Benefits Guide medical plan comparison charts for convenient at-a-glance referencing, enrollment instructions, and plan contact information. Please review your materials carefully, and choose the plans that best meet your needs.

The benefits and premium costs contained in this Benefits Guide are effective June 1, 2018 through May 31, 2019.

We encourage you to use this Benefits Guide as a reference throughout the plan year. If you have questions, contact the Human Resources Benefits Unit or the plan providers directly.

ANNUAL ENROLLMENT

Annual Enrollment is **Monday, March 12, 2018 through Friday, March 30, 2018**. During this period, you may:

- Enroll in coverage
- Change medical plan
- Add/Drop/Waive dependents from your coverage
- Decline medical coverage
- Waive medical coverage (if enrolled in other Group Coverage or Covered CA)

WHAT'S NEW AND DIFFERENT

New Rates. Kaiser Permanente Plans' premiums are increasing 6.6%. Sutter Health Plus Plans' premiums are increasing between 4.7% and 6.2%, and Western Health Advantage Plans' premiums are increasing 6.7%.

SUMMARY OF BENEFITS AND COVERAGE

You may view the Summary of Benefits and Coverage (SBC) information for each of the County's medical plans and Uniform Glossary online at:http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

More information on these medical plan options can be found on the Annual Enrollment website. Please note that Extra-Help Employees eligibility is limited to medical plan coverage, excluding the County Health Plans (PPO and EPO), CareCounsel Patient Advocacy, and the Employee Assistance Plan through ValueOptions only.

Any coverage elected during the Annual Enrollment period will be in effect for the 2018-2019 plan year, which begins June 1, 2018 and ends May 31, 2019. If you decline coverage, your next opportunity to enroll in a County-sponsored medical plan will be during the 2019 Annual Enrollment period, unless you have a mid-year qualifying event and notify the HR Benefits Unit within 31 days of the event.

2018 ANNUAL ENROLLMENT MEETING SCHEDULE

Benefits are an important part of your total compensation package. Take advantage of this opportunity to review your benefit plan options. **Please allow up to 2 hours per session.** *You may attend these meetings on County-paid time with supervisory approval.*

DATE	TIME	DEPT/LOCATION	STREET ADDRESS	ROOM
March 13	9:00 a.m. - 11:00 a.m.	Employment and Training	2227 Capricorn Way, Suite 100	Santa Rosa Conference Room
	2:00 p.m. - 4:00 p.m.	Economic Assistance	2550 Paulin Dr., 2nd Floor	Cypress Room
March 14	9:00 a.m. - 11:00 a.m.	Adult and Aging Services	3725 Westwind Blvd., Suite 101	Carnelian Room
	2:00 p.m. - 4:00 p.m.	Sonoma County Sheriff's Office	2796 Ventura Ave.	Training Room
March 15	7:30 a.m. - 9:30 a.m.	Transportation & Public Works (TPW) - Road Maintenance	2175 Airport Blvd.	Conference Room
	10:30 a.m. - 12:30 p.m.	Sonoma County Water Agency	404 Aviation Blvd.	Redwood Rooms
	2:00 p.m. - 4:00 p.m.	Child Support Services (DCSS)	3725 Westwind Blvd., Suite 200	Conference Room C
March 19	10:00 a.m. - 12:00 p.m.	Department of Health Services (DHS)	625 5th Street	City View Room
	2:00 p.m. - 4:00 p.m.	Department of Health Services (DHS)	490 Mendocino Ave., 2nd Floor	Manzanita Conference Room
March 20	9:00 a.m. - 11:00 a.m.	Family, Youth & Children's Services	1202 Apollo Way	Annadel East Room
	3:00 p.m. - 5:00 p.m.	Employment and Training	2227 Capricorn Way, Suite 100	Santa Rosa Conference Room
March 21	8:00 a.m. - 10:00 a.m.	Economic Assistance	520 Mendocino Ave.	Madrone Room
March 22	9:00 a.m. - 11:00 a.m.	HSD Fiscal Administration	3600 Westwind Blvd.	Wright Brothers Room
	3:00 p.m. - 5:00 p.m.	Economic Assistance	520 Mendocino Ave.	Madrone Room
March 27	10:00 a.m. - 12:00 p.m.	Permit & Resource Management (PRMD)	2550 Ventura Ave.	PRMD Hearing Room
	3:00 p.m. - 5:00 p.m.	Community Development Commission	1440 Guerneville Rd.	Hearing Room
March 28	9:00 a.m. - 11:00 a.m.	County Administration	575 Administration Dr., Suite 102A	Board of Supervisors' Chambers
	1:00 p.m. - 3:00 p.m.	SCERA	433 Aviation Blvd., Suite 100	Board Room

SUBMITTING ANNUAL ENROLLMENT PERIOD ELECTIONS AND DEADLINES

Benefit elections and/or changes to your existing benefits are made online through the County's Employee Self-Service (ESS) system. A link will be e-mailed to you on the first day of the Annual Enrollment Period. Save the e-mail until you are ready to make your benefit elections.

ESS is also accessible via Employee Self-Service eP the link located on the County of Sonoma Intranet (under "Resources" on the right side of the Intranet home page) or on the County's Internet home page under "Employee Resources" (located on the bottom of the page). From the Employee Resources Internet page, select Employee Self-Service from the left menu.

Log into the Employee Self-Service (ESS) system using your ESS password. Forgot your password? Manage your password using the link on the bottom of the ESS webpage.

To begin the benefit enrollment/changes process (after logging in), select ***Extra Help Annual Enrollment*** located under Benefits section on the lower left side of the Employee Self-Service home page. Employee Self-Service (ESS) support and step-by-step instructions are available, so please make every effort to utilize the online system. However, if you are unable to access the Employee Self-Service system, you may complete and submit a paper enrollment form. The County of Sonoma Extra-Help Enrollment/Change Form is available on the County of Sonoma Human Resources web site: http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/

BENEFIT ELIGIBILITY

Benefits must be offered to you through a Memorandum of Understanding (MOU) or Salary Resolution.

To be initially eligible for medical benefits listed in this Benefits Guide, you must meet the following criteria before payroll deductions begin:

1. Must generally be scheduled to work at least forty (40) hours per pay period, and
2. Worked at least eighty (80) hours in the previous two (2) pay periods.

DEPENDENT ELIGIBILITY

If you are eligible to participate in County-sponsored medical plan, your eligible dependents may also participate. Your eligible dependents include:

- Your lawfully married spouse
- Your domestic partner
- Your or your spouse/domestic partner's dependents including son, daughter, step-son, step-daughter, legally adopted child, a child placed with you for adoption, eligible foster child, or child for whom you are the legally appointed guardian

- Child under a QMCSO

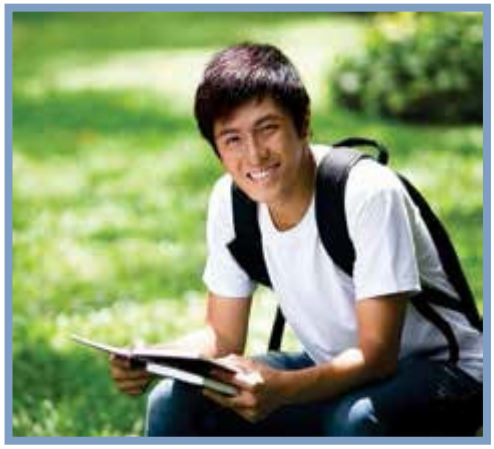
Dependent coverage will end the last day of the month in which the dependent no longer meets the eligibility requirements.

Continued Coverage and Conditions for Regaining Eligibility for Medical Plan

Once enrolled in a medical plan, an Extra-Help employee who fails to work at least twenty (20) hours in any pay period in which a premium deduction was due, will be continue to be eligible for medical plan coverage by paying the full amount of the premiums by payroll deduction. If the employee's pay check is insufficient to fully cover the deduction, the employee must make arrangements to pay the premium directly to ATTC's Payroll Office. Premiums are due in the ACTTC's Payroll Office by the last day of the pay period in which there were insufficient hours worked. Failure to pay premiums will result in loss of coverage.

Please reference your Sonoma County Salary Resolution or applicable Bargaining Unit Memorandum of Understanding for additional information about Extra-Help benefits and stipulations to continue medical plan coverage.

SOCIAL SECURITY NUMBERS FOR YOUR DEPENDENTS ARE REQUIRED.



You are required to provide a Social Security number (SSN) or a Federal Tax Identification number (TIN) for your dependent(s) when you enroll them in a County-sponsored medical plan. The County needs this information to comply with IRS reporting and the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE. If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please provide the Social Security number to the Human Resources Benefits Unit.

This Annual Enrollment Period is your opportunity to add, drop, or waive coverage for your dependents and to ensure that our records accurately reflect your benefit elections. **If an eligible dependent is not listed in Employee Self-Service in each of your medical plan, that dependent will not be covered and will not be able to access benefits when seeking services.** Dependents who are no longer eligible should be removed from coverage and failure to do so in a timely manner may result in your liability to repay the Plan if any benefits are paid to or on behalf of an ineligible person.

PREMIUM COST FOR MEDICAL PLANS

COUNTY CONTRIBUTION TOWARD MEDICAL COVERAGE FOR EXTRA-HELP

There is no change to the County Contribution for medical coverage for Extra-Help employees. The maximum County contribution amount per month is $400 ($200 semi-monthly). The County's contribution is pro-rated based on the hours worked in a pay period:

- If you work 40 hours or more in a pay period, you receive the full semi-monthly pay period County contribution of $200.
- If you work 20 hours or more, but less than 40 hours in a pay period, you receive a prorated County contribution based on the hours you work.
- If you work less than 20 hours in a pay period, no County contribution will be paid.

MEDICAL PLAN PREMIUM COLLECTION

Premium deductions for coverage elected during Annual Enrollment begin May 2, 2018 for coverage effective June 1, 2018. Premiums are collected in the month prior to coverage. Premiums for the plan will be paid in advance on the first two pay dates of the month prior to the coverage effective date and on the first two pay dates of every month thereafter. When there is a third pay check in a month, no premiums will be collected from that third pay check. When payment has been made in full, coverage will take effect on the first of the month following payment and shall end on the last day of the same month. Coverage will be month to month and is dependent on full payment of premiums and subject to continued eligibility.

The employee premiums shall be paid through pre-tax payroll deduction as allowed by IRS Code Section 125.

2018 – 2019 EXTRA-HELP SEMI-MONTHLY PREMIUM RATES			
Plan	**Total Premium Cost**	**County Contribution**	**Employee Contribution**
Kaiser Permanente Traditional HMO			
Single	$392.79	$200.00	$192.79
Two-Party	$785.58	$200.00	$585.58
Family	$1,111.60	$200.00	$911.60
Sutter Health Plus Traditional HMO			
Single	$304.88	$200.00	$104.88
Two-Party	$609.81	$200.00	$409.81
Family	$862.98	$200.00	$662.98
Western Health Advantage Traditional HMO			
Single	$370.49	$200.00	$170.49
Two-Party	$740.99	$200.00	$540.99
Family	$1,048.49	$200.00	$848.49
Kaiser Permanente Hospital Services DHMO			
Single	$316.26	$200.00	$106.26
Two-Party	$632.52	$200.00	$432.52
Family	$895.02	$200.00	$695.02
Sutter Health Plus Hospital Services DHMO			
Single	$261.61	$200.00	$61.61
Two-Party	$523.24	$200.00	$323.24
Family	$740.45	$200.00	$540.45
Western Health Advantage Hospital Services DHMO			
Single	$299.64	$200.00	$99.64
Two-Party	$599.29	$200.00	$399.29
Family	$848.01	$200.00	$648.01
Kaiser Permanente Deductible First HDHP			
Single	$293.47	$200.00	$93.47
Two-Party	$586.94	$200.00	$386.94
Family	$830.52	$200.00	$630.52
Sutter Health Plus Deductible First HDHP			
Single	$242.85	$242.85	$0.00
Two-Party	$485.70	$200.00	$285.70
Family	$687.27	$200.00	$487.27
Western Health Advantage Deductible First HDHP			
Single	$278.33	$200.00	$78.33
Two-Party	$556.67	$200.00	$356.67
Family	$787.68	$200.00	$587.68

WHAT IF I WANT TO CONTINUE MY CURRENT ELECTIONS?

If you take no action your current benefit election will continue effective June 1, 2018 through May 31, 2019. Be aware, that making no change is considered an election to retain the benefits currently in place for the upcoming plan year. At a minimum, attend an Annual Enrollment meeting, verify and confirm your dependents, and ensure that only your eligible dependents are covered.

WHAT IF I WANT TO MAKE A CHANGE MID-YEAR?

In accordance with a federal law, which grants the ability for employers to offer non-taxable benefits to employees, plan elections are irrevocable for the plan year unless a qualifying mid-year Change-in-Status event is experienced. Requirements of a mid-year change are:

1. Requested change must be consistent with the qualifying mid-year event;
2. Meet the guidelines of County contracts/agreements, plan documents, and IRC Section 125; and
3. Be received by the HR Benefits Unit within **31 days** of the qualifying mid-year event

To view a summary of the most common qualifying mid-year Change-in-Status events, please refer to the Section 125 Change-of-Status Events and Mid-Year Enrollment Changes matrix.

EFFECTIVE DATE OF MID-YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective on the first day of the month following or coinciding with the date the completed Extra-Help Employee Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit. (The exception is that when enrollment is requested for a newborn, newly adopted child or child placed for adoption, coverage is effective on the date of birth or adoption or placement for adoption). For New Hires, elections are effective on the first day of the month following the date of hire in a benefits-eligible position, including those hired on the first day of the month.

Elections that cancel or drop coverage will be effective on the last day of the month following or coinciding with the date the completed Extra-Help Employee Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit.

If your coverage was terminated or lapsed while on leave, you will need to complete a new Extra-Help Employee Enrollment/Change Form upon return from your leave. Your coverage will be effective on the first day of the month following your return from leave. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

You will be billed for any premiums owed as a result of your re-enrollment and for the addition of any eligible dependents. If the Change-in-Status event results in a decrease in premiums, you will receive a

refund on a subsequent pay warrant for the premium overpayment. To reduce the amount of premiums owed or to avoid incurring an overpayment of premiums, you are encouraged to submit your paperwork as soon as possible.

FOR NEWBORN CHILDREN

Newborn children must be enrolled in County plan coverage to receive benefits under the plan. Failure to request enrollment for your newborn in a County plan within 31 days of the date of birth will result in your newborn not having coverage from date and time of birth forward for most plans. You will be liable for any services and/or expenses incurred for that newborn who is not timely and properly enrolled.

To enroll your newborn, submit a completed Employee Election/Change Form to the Human Resources Benefits Unit within 31 days of the newborn's date of birth. If enrollment is requested timely, coverage must be retroactively effective to the date of birth, adoption or placement for adoption. You are encouraged to request newborn enrollment and submit enrollment paperwork as soon as possible (and no later than 31 days after the date of birth) to avoid non-coverage for your newborn child.

When properly enrolled, the newborn will be assigned under the medical group to which the parent is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES MATRIX

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

	Life / Family Events	
If you experience the following Event...	**You may make the following change(s)[1] within 31 days of the Event…**	**YOU MAY NOT make these types of Changes**
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans	• Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Drop dependent child(ren) if show proof of other coverage under spouse's plan • Children of a Domestic Partner MUST be dropped (regardless of whether they enroll in other coverage) as they are no longer eligible dependents • Enroll yourself and your dependent children if you or at least one dependent child was previously enrolled in your spouse/DP's plan and lost eligibility • Change health plans	• Drop health coverage for yourself
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents o Adoption placement papers are required • Change health plans	• Drop health coverage for yourself or any other covered individuals without proof of enrollment in spouse/DP's plan
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Drop health coverage for yourself • Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (e.g. child reaches the maximum age for coverage) or death of a dependent child	• Drop the child who lost eligibility from your health coverage • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals	• Drop health coverage for yourself or any other covered individuals
Death of a spouse/DP	• Drop the deceased dependent from your health coverage • Enroll yourself and/or any eligible children if lost eligibility under spouse's/DP's plan • Change health plans	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to Medicare	• Drop coverage for the Dependent who became entitled to Medicare, with proof of Medicare enrollment • If Employee becomes entitled to Medicare, may drop all coverage (self and dependents) o Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Change of home address outside of plan service area that causes a loss of eligibility for coverage	• If you are enrolled in an HMO and move out of their service area, then you can change health plans	• Cannot add eligible dependents • Does not apply to County Health Plan, dental or vision coverage

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

	Life / Family Events	
If you experience the following Event...	**You may make the following change(s)[2] within 60 days of the Event…**	**YOU MAY NOT make these types of Changes**
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP [2]	• Drop coverage for the Dependent who became entitled to Medicaid, Medi-Cal, or SCHIP with proof of Medicaid/Medi-Cal or SCHIP enrollment • Drop coverage for yourself with proof of your own Medicaid/Medi-Cal/SCHIP enrollment o Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person lost entitlement to Medicaid, Medi-Cal or SCHIP	• Add the person who lost entitlement to Medicaid, Medi-Cal, or SCHIP • If you or an eligible dependent is gaining eligibility for premium assistance, may enroll those gaining eligibility for premium assistance only if not already enrolled in County coverage	• Drop coverage for yourself or any enrolled dependents • Change plans
	Employment Status Events	
If you experience the following Event...	**You may make the following change(s)[1] within 31 days of the Event…**	**YOU MAY NOT make these types of Changes**
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents	• Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage if they enroll in spouse's or DP's coverage • Drop coverage for yourself if you enroll in your spouse's/DP's coverage o Proof of coverage in the other health plan required	• Change health plans. • Add any eligible dependents to your health coverage. • Enroll yourself if you are not currently enrolled
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage or eligibility for health benefits in another group, individual, or exchange health plan. You or your dependents exhaust COBRA coverage under other group health plan.	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans o Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• You must drop coverage for yourself and any enrolled Dependents because you are no longer eligible for coverage	• Add any Dependents

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

	Employment Status Events	
If you experience the following Event...	**You may make the following change(s)[1] within 31 days of the Event…**	**YOU MAY NOT make these types of Changes**
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase	• Drop coverage for yourself (only if there is a significant cost change and there is no other similar health plan option available) • Change health plans to a less expensive plan	• No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.
You experience an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution	• You may suspend coverage for yourself and dependents while on leave and reinstate coverage upon return to work if you are still eligible then	• Add or Drop any dependents, change plans, or enroll if not currently enrolled
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	• Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans	• No change is allowed unless the increase in hours results in new eligibility or a significant change in the employer subsidy for medical (not FSA) coverage
You return from Military leave	• Prior elections at beginning of leave are reinstated unless another Change Event has occurred which permits the change	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself o Proof of enrollment in Marketplace Coverage is required	• Add any dependents, change plans, or enroll yourself if not currently enrolled

[1] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.
[2] You have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.

MEDICAL BENEFITS

The County of Sonoma cares about your health and well-being and is pleased to offer you a choice of medical plan options. You are eligible to choose from the following medical plans:

- Kaiser Permanente HMO (Health Maintenance Organization)
- Kaiser Permanente Hospital Services DHMO (Deductible HMO Plan)
- Kaiser Permanente Deductible First HDHP (High Deductible Health Plan)
- Sutter Health Plus HMO (Health Maintenance Organization)
- Sutter Health Plus Hospital Services DHMO (Deductible HMO Plan)
- Sutter Health Plus Deductible First HDHP (High Deductible Health Plan)
- Western Health Advantage HMO (Health Maintenance Organization)
- Western Health Advantage Hospital Services DHMO (Deductible HMO Plan)
- Western Health Advantage Deductible First HDHP (High Deductible Health Plan)

When you enroll in a medical plan, you also decide if you want to enroll your eligible dependents in coverage. You can choose one of three coverage levels, as follows:

- Self only
- Self and 1 dependent
- Self and 2 or more dependents

KAISER PERMANENTE PLANS

Easy Access: With Kaiser Permanente it's simple to find the care you need. Along with primary care, urgent care, emergency care, and labor and delivery, members have convenient access to a wide choice of specialty services with facilities in Sonoma County, Marin County, and access to Kaiser Permanente throughout California.

Personalized care: Whether you come into a Kaiser Permanente facility for a routine visit, urgent care, or emergency care, your doctors, nurses, and specialists have access to your electronic medical record. You have expanded opportunities to interact with care team the way you want: in person, physician email, 24 hour advice nurse line, linked to your medical record, telephone appointments and video visits are possible.

To learn more about Kaiser Permanente, visit us at www.my.KP.org/sonomacounty or call (800) 464-4000.

Coordination of Benefits with 2 or More HSA-Qualified HDHPs: To better align with federal tax laws, starting January 1, 2018, Kaiser Permanente will coordinate benefits for members with 2 or more employer-sponsored Kaiser Permanente health savings account (HSA)-qualified high deductible health plans (HDHPs). Dual covered members who have 2 or more Kaiser Permanente plans that are not HSA qualified HDHPs or who have a Kaiser Permanente HSA-qualified HDHP and a non-HSA-qualified HDHP will not be impacted by this change. Dual-covered members with Kaiser Permanente Individuals and Families (KPIF) HSA-qualified HDHPs with will also not be impacted by this change.

KAISER PERMANENTE TRADITIONAL HMO

The Traditional $10 Copay Plan provides doctor and specialist visits for a $10 copay. Prescription medication is covered at a copay of $5 for generic and $10 for brand (up to a 100 day supply). Hospitalization, radiology, and lab tests are also covered at no cost. Most preventive services are also covered at no cost under ACA guidelines. Generally, you must use Kaiser Permanente's physicians unless you have an out-of-area urgent or emergency situation or a referral.

KAISER PERMANENTE HOSPITAL SERVICES DHMO

For hospital related services including emergency room visits, inpatient stays, and outpatient surgery, you pay the full cost of these services up to the deductible then a 20% coinsurance until you reach your out-of-pocket max. The out-of-pocket maximum includes the calendar year deductible, copayments, and coinsurance. For most primary care, specialist, and urgent care visits you will pay a $20 copay. For prescription drugs you will pay $10 for a 30 day supply and $20 for a 100 day supply for generic and for brand $30 for a 30 day and $60 for a 100 day supply for brand.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Kaiser out-of-pocket expenses for reimbursement.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimate.

KAISER PERMANENTE DEDUCTIBLE FIRST HDHP

This plan requires a member to meet the calendar year deductible FIRST before ANY plan benefits will be paid, except covered preventive services. Members will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is met, covered medical, hospital, and prescription benefits will be provided for a copayment or coinsurance amount. While this plan does require a member to meet the deductible first, members who anticipate a hospital stay (such as a surgery or the birth of a child), may find this plan offers a lower total out-of-pocket cost. The calendar year out-of-pocket maximum includes: calendar year deductibles, copayments, and coinsurance.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Kaiser out-of-pocket expenses for reimbursement.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimate.

Take Note… If you (the employee) elect to enroll in this Deductible First HDHP, which qualifies as an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out-of-pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

SUTTER HEALTH PLUS PLANS

Affordability. Access. Quality. Sutter Health Plus is a local not-for-profit HMO that gives members affordable access to a network of high-quality providers. The health plan's network in Sonoma County includes Sutter Santa Rosa Regional Hospital and Novato Community Hospital (serving southern Sonoma County), Sutter Pacific Medical Foundation, Sutter Medical Group of the Redwoods, Sutter Santa Rosa Urgent Care, and Sutter Walk-In Care facility located in Petaluma.

Features and Benefits

Take a moment to learn about the Sutter Health Plus:

- Comprehensive benefits and coverage for hospitalization, urgent care, primary care, specialty care, X-ray, laboratory, prescription drug coverage, and more
- Coverage for a variety of no-cost preventive care services to help prevent or detect health problems early on
- Easy to use online tools, such as:
  - A Member Portal that gives members access to important plan documents; eligibility, benefits and copay information; forms and resources; change primary care physician (PCP); request or print member identification cards
  - My Health Online (not offered by all providers) to schedule appointments, email doctors, view test results, and access records
- Many Sutter Health Plus providers use an electronic health record
- Mail order pharmacy program and conveniently located retail pharmacies
- Coverage for emergency and urgent care anywhere in the world
- A year-round 24/7 nurse advice line
- Wellness Coaching Program to help with healthy weight, tobacco cessation, and stress management—all at no additional out-of-pocket costs

Plan Offerings

Sutter Health Plus has three plan offerings available for county of Sonoma employees, to meet a variety of needs.

- Traditional $10 Copay Plan – ML42
- Hospital Services DHMO – ML21
- Deductible First HDHP – HD 11

For more information about Sutter Health Plus or to view the plan comparisons, visit www.sutterhealthplus.org/sonoma-county or call Member Services (855) 315-5800.

SUTTER HEALTH PLUS TRADITIONAL HMO

Traditional HMO ML42 $10 copay plan for primary care, specialist, or chiropractic visits. Chiropractic visits are limited to 20 visits per year. Prescription medications are available through retail or mail order at a copay range of $5 - $40.

SUTTER HEALTH PLUS HOSPITAL SERVICES DHMO

Hospital Services DHMO ML21 $20 copay plan for primary care, specialist, or chiropractic visits. Chiropractic visits are limited to 20 visits per year. Prescription medications are available through retail or mail order at a copay range of $10 - $120. Tier 4 prescription medications are covered at a 20% coinsurance, not to exceed $100 per prescription.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Sutter Health Plus out-of-pocket expenses for reimbursement.

SUTTER HEALTH PLUS DEDUCTIBLE FIRST HDHP

The Sutter Health Plus HDHP HD 11 offers a lower monthly premium and higher deductible limits than the two other Sutter HMO plans. After a member meets the deductible, the plan pays for a percentage of medical care until the member reaches the annual out-of-pocket maximum.

Deductible First HD 11 $20 copay per visit for primary care and specialist visits after the deductible is met. Prescription medications are available through retail or mail order at a copay range of $10 - $120 after the deductible is met. Tier 4 prescription medications are covered at a 20% coinsurance, not to exceed $100 per prescription after the deductible is met.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Sutter Health Plus out-of-pocket expenses for reimbursement.

Take Note… If you (the employee) elect to enroll in this Deductible First HDHP, which qualifies as an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out-of-pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

WESTERN HEALTH ADVANTAGE PLANS

With Western Health Advantage you don't have to settle for one medical group. Our unique **Advantage Referral** program gives you access to many of the specialist physicians across our eight medical groups, including: Canopy Health, Hill Physicians, John Muir Health, Meritage Medical Network, Mercy Medical Group, NorthBay Healthcare, UC San Francisco medical system, and Woodland Healthcare. We give you the freedom and flexibility you are looking for in a health plan.

Western Health Advantage has you covered. Enjoy the peace-of-mind that comes with 27 leading hospitals and major medical centers in Northern California, including five in Sonoma County (Healdsburg District Hospital, Petaluma Valley Hospital, Santa Rosa Memorial Hospital, Sonoma Valley Hospital, and Sonoma West Medical Center). You will also find conveniently located full-service care centers that offer a wide array of services under one roof — providing access to quality care in a neighborhood near you.

Most preventive services — such as well baby/child visits, immunizations, physicals, mammograms, and routine preventive screenings — are covered at no cost. Membership with WHA means value-added benefits including acupuncture and chiropractic services, mental health and substance abuse services, online wellness assessment, travel assistance, and more.

Like all HMOs, you must use Western Health Advantage's providers, except when you need emergency care.

- **New! WHA Expands into the Bay Area:** We are pleased to announce our expansion into four new counties: San Francisco, Alameda, Contra Costa, and part of San Mateo. With this expansion, we have added premier medical systems to our WHA network including John Muir Health and the UC San Francisco medical system through Canopy Health. The WHA network has grown to 5,800 doctors and specialists from eight medical groups. Please note that eligibility to enroll in the new Canopy Health expansion will require a member to live or work in the service area. You are encouraged to view our enhanced provider search at www.choosewha.com/directory.
- **New! Active & Fit Direct:** WHA has added more fitness options, including Active & Fit, which has over 9,000 fitness centers. Learn more at www.mywha.org/gyms.
- **New! Smart90 with Express Scripts:** WHA has more choices for getting 90-day supplies of prescriptions, including the Smart90 program, which allows three-month refills at Walgreens.
- **New! $0 cost, high-value drugs:** WHA has made certain non-preventive drugs available at no cost (after deductible, if applicable).

To learn more about Western Health Advantage, visit us at www.chooseWHA.com/Sonoma-county or call (888) 563-2250.

WESTERN HEALTH ADVANTAGE TRADITIONAL HMO

Primary care doctor and specialist visits are available for a $10 copay. Hospitalization, radiology, and lab tests are covered at no cost from Western Health Advantage HMO. Outpatient prescription medication is covered at a copay range of $5 - $20.

WESTERN HEALTH ADVANTAGE HOSPITAL SERVICES DHMO

The Hospital Services DHMO plan requires you to live within the plan's Northern California service area and to receive your non-emergency care from Western Health Advantage providers. You share in the cost of your care through copayments, coinsurance, and deductibles.

Most doctor's office visits, radiology services, lab tests and prescriptions are available for a copay or coinsurance amount, even before you have reached the calendar year deductible.

Hospitalizations, residential treatment facility, emergency room care, in-patient, and out-patient surgeries are subject to the calendar year deductible before plan benefits will be paid.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Western Health Advantage out-of-pocket expenses for reimbursement.

WESTERN HEALTH ADVANTAGE DEDUCTIBLE FIRST HDHP

The Deductible First HDHP plan requires you to live within the plans' Northern California service area and to receive care from Western Health Advantage providers. This means you have access to Western Health Advantage providers only, except when you need emergency care. You share in the cost of your care through co-payments, coinsurance, and deductibles.

For any service other than preventative services, a member must meet the calendar year deductible FIRST before ANY plan benefits will be paid. A member will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is satisfied, covered medical, hospital, and prescription benefits will be provided for a copayment or coinsurance amount (if applicable).

See the Medical Plan Comparison Chart for more information about deductibles, out-of-pocket maximums, and plan benefits.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit Western Health Advantage out-of-pocket expenses for reimbursement.

Take Note… If you (the employee) elect to enroll in this Deductible First HDHP, which qualifies as an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute

to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out-of-pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

Dual Coverage Not Allowed Reminder… *An eligible employee/retiree and his/her eligible dependent(s) may be enrolled in a County-offered medical plan, but are allowed only to enroll either as a subscriber in a County-offered medical plan or, as the dependent spouse/domestic partner of another eligible County employee/retiree, but not both. If an employee/retiree is also eligible to cover his/her dependent child/children, each child will be allowed to enroll as a dependent on only one employee's or retiree's plan (i.e., a retiree and his or her dependents cannot be covered by more than one County- offered plan).*

MEDICAL PLAN COMPARISON CHART - HMO PLANS

Plan Information	Kaiser Permanente HMO Group # 602483-0003	Sutter Health Plus HMO - ML42 Group # 131802-000001	Western Health Advantage HMO Group # 950201-A000
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California.	Based on residential zip code. Must live or work in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	None	None	None
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$10 Copay	$10 Copay	$10 Copay
Preventive Care Birth to Age 18	No Charge	No Charge	No Charge
Preventive Care Adult Routine Care	No Charge	No Charge	No Charge
Preventive Care Adult Routine OB/GYN	No Charge	No Charge	No Charge

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO** Group # 602483-0003	**Sutter Health Plus HMO - ML42** Group # 131802-000001	**Western Health Advantage HMO** Group # 950201-A000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-Ray	No Charge	No Charge	No Charge
Physical Therapy (medically necessary treatment only)	$10 Copay	$10 Copay	$10 Copay
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** $10 Copay Up to 20 visits per year (Chiro-practic services do not apply to out-of-pocket maximums) **Acupuncture:** PCP referral $10 copay LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic:** $15 Copay Up to 20 visits per year **Acupuncture:** $15 Copay Up to 20 visits per year
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$10 copay individual therapy $5 copay group therapy	$10 copay individual therapy $5 copay group therapy	$10 copay individual or group therapy
Family Planning Counseling and Consultation	No Charge	No Charge	No Charge
Routine Eye Exams with Plan Optometrist	No Charge	No charge for annual refractive eye exam	No Charge
Hearing Exam	No Charge	No Charge	No Charge
Allergy Injections (serum included)	$3 Copay	$10 Copay	$3 Copay
Infertility Services	$10 Copay	50% Coinsurance (Infertility services do not apply to out-of-pocket maximum)	$10 Copay
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO** Group # 602483-0003	**Sutter Health Plus HMO - ML42** Group # 131802-000001	**Western Health Advantage HMO** Group # 950201-A000
SURGICAL AND HOSPITAL SERVICES			
Outpatient Surgery	$10 Copay	$10 Copay per visit	$10 Copay
Maternity	No charge	No charge	No charge
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
Ambulance	$50 per trip	$50 per trip	$50 per trip
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	No charge	No charge	No charge
Skilled Nursing Facility	No Charge Up to 100 days per benefit period	No Charge Up to 100 days per benefit period	No Charge Up to 100 days per benefit period
Home Health	No Charge Up to 100 visits per year	No Charge Up to 100 visits per calendar year	No Charge Up to 100 visits per year
Urgent Care	$10 Copay	$15 Copay	$10 Copay
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% coinsurance in accordance with formulary	No charge	20% coinsurance

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO** Group # 602483-0003	**Sutter Health Plus HMO - ML42** Group # 131802-000001	**Western Health Advantage HMO** Group # 950201-A000
PRESCRIPTION DRUGS			
Generic or Tier 1	$5 Copay Up to 100 day supply	$5 Copay Up to 30 day supply	$5 Copay Up to 30 day supply
Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$10 Copay Up to 30 day supply	$10 Copay Up to 30 day supply
Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	**Tier 3** - $20 Copay Up to 30 day supply **Tier 4 (Specialty Drug)** - $20 Copay Up to a 30 day supply only	$20 Copay Up to 30 day supply
Mail Order Benefit Generic or Tier 1	$5 Copay Up to 100 day supply	$10 Copay Up to 100 day supply	$5 Copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$20 Copay Up to 100 day supply	$10 Copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	$40 Copay Up to 100 day supply	$20 Copay Up to 90 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 602484-0006	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000005	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California	Based on residential zip code. Must live or work in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,000 **Any One Member in a family of two or more:** $1,000 **Family of two or more:** $2,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $4,000 **Any One Member in a family of two or more:** $4,000 **Family of two or more:** $8,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $4,000 **Any One Member in a family of two or more:** $4,000 **Family of two or more:** $8,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS			
Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 602484-0006	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000005	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-Ray	**Diagnostic Lab:** $10 copay per encounter, no deductible **Diagnostic X-ray:** $10 copay per encounter, no deductible **CT/PET Scans & MRI:** $50 per procedure, no deductible	**Diagnostic Lab:** $20 copay, no deduction **Diagnostic X-ray:** $10 copay per procedure, no deductible **CT/PET Scans & MRI:** $50 per procedure, no deductible	**Diagnostic Lab:** no charge, no deductible **Diagnostic X-ray:** no charge, no deductible
Physical Therapy (medically necessary treatment only)	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** $20 Copay, no deductible up to 20 visits per year (Chiropractic services do not apply to out-of-pocket maximums) **Acupuncture:** PCP referral $20 copay LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic** $15 Copay, no deductible. Up to 20 visits per year **Acupuncture:** $15 Copay, no deductible. Up to 20 visits per year
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$20 copay MH/SUD individual, no deductible $10 copay MH group, no deductible $5 copay SUD group, no deductible	$20 copay MH/SUD individual, no deductible $10 copay MH/SUD group, no deductible	$20 copay, no deductible
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 copay, no deductible
Routine Eye Exams with Plan Optometrist	No charge, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	No charge, no deductible	$20 copay, no deductible	No charge, no deductible
Infertility Services	50% coinsurance, no deductible	50% coinsurance, no deductible (Infertility services do not apply to out-of-pocket maximum)	50% coinsurance, no deductible
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS			
Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 602484-0006	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000005	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201
SURGICAL AND HOSPITAL SERVICES			
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Maternity	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible)
Ambulance	$150 per trip, no deductible	No charge after deductible	$150 per trip, no deductible
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	20% coinsurance, no deductible Up to 100 days per benefit period	20% coinsurance, after deductible Up to 100 days per benefit period	20% coinsurance after deductible Up to 100 days per benefit period
Home Health	No Charge, No Deductible Up to 100 visits per year	No Charge, No Deductible Up to 100 visits per calendar year	No Charge, No Deductible Up to 100 visits per year
Urgent Care	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% coinsurance in accordance with formulary, no deductible	20% coinsurance after deductible	20% coinsurance, no deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 602484-0006	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000005	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201
PRESCRIPTION DRUGS			
Generic or Tier 1	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply, no deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	**Tier 3** - $60 copay up to 30 day supply, no deductible **Tier 4 (Specialty Drug)** - 20% coinsurance up to a maximum of $100 per prescription up to 30 day supply, no deductible	$50 copay up to 30 day supply, no deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply, no deductible	$20 copay up to 100 day supply, no deductible	$20 copay up to 90 day supply, no deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply, no deductible	$60 copay up to 100 day supply, no deductible	$60 copay up to 90 day supply, no deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply, no deductible	$120 copay up to 100 day supply, no deductible	$100 copay up to 90 day supply, no deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	**Kaiser Permanente** **Deductible First HDHP** Group # 602484-0009	**Sutter Health Plus** **Deductible First HDHP - HD 11** Group # 131802-000009	**Western Health Advantage** **Deductible First HDHP** Group # 950201
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California	Based on residential zip code. Must live or work in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual:** $1,350 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $2,700	**Individual:** $1,500 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $3,000	**Individual:** $1,350 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $2,700
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	Kaiser Permanente Deductible First HDHP Group # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	Western Health Advantage Deductible First HDHP Group # 950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-Ray	**Diagnostic Lab:** $10 copay per encounter after deductible **Diagnostic X-ray:** $10 copay per encounter after deductible	**Diagnostic Lab:** $20 copay after deductible **Diagnostic X-ray:** $10 copay per procedure after deductible **CT/PET Scans & MRI:** $50 per procedure after deductible	No charge after deductible
Physical Therapy (medically necessary treatment only)	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** Not covered **Acupuncture:** PCP referral $20 copay after deductible LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	No charge after deductible Up to 20 visits per year
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$20 copay MH/SUD individual, after deductible; $10 copay MH group, after deductible; $5 copay SUD group, after deductible	$20 copay MH/SUD individual after deductible $10 copay MH/SUD group after deductible	$20 copay after deductible
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 copay after deductible
Routine Eye Exams with Plan Optometrist	$20 copay, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	$5 copay after deductible	$20 copay after deductible	$5 copay after deductible
Infertility Services	Not covered	Not covered	50% coinsurance, no deductible
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	$250 copay per admission after deductible	**Hospitalization Facility Fee:** $250 copay per day, up to 5 days after deductible **Inpatient Physician Services:** No charge after deductible	$250 copay per admission after deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	Kaiser Permanente Deductible First HDHP Group # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	Western Health Advantage Deductible First HDHP Group # 950201
SURGICAL AND HOSPITAL SERVICES			
Outpatient Surgery	$150 copay per procedure after deductible	**Outpatient Surgery Fee:** $20 copay per visit after deductible	$150 copay per procedure after deductible
Maternity	$250 copay per admission after deductible	**Delivery and hospital inpatient services**: $250 copay per day, up to 5 days after deductible	$250 copay per admission after deductible
Emergency Room	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible
Ambulance	$100 copay per trip, after deductible	$100 copay per trip, after deductible	$100 copay per trip, after deductible
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	$250 copay per admission after deductible	**MH/SUD Inpatient Facility:** $250 copay per day, up to 5 days after deductible **MH/SUD Inpatient Physician Services:** No charge after deductible	$250 copay per admission after deductible
Skilled Nursing Facility	$250 copay per admission after deductible Up to 100 days per benefit period	$100 copay per day up to 5 days after deductible Up to 100 days per benefit period	$250 copay per admission after deductible Up to 100 days per benefit period
Home Health	No charge after deductible Up to 100 visits per year	No charge after deductible Up to 100 visits per calendar year	No charge after deductible Up to 100 visits per year
Urgent Care	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% co-insurance in accordance with formulary after deductible	20% coinsurance after deductible	20% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS			
Plan Information	**Kaiser Permanente Deductible First HDHP** Group # 602484-0009	**Sutter Health Plus** **Deductible First HDHP - HD 11** Group # 131802-000009	**Western Health Advantage Deductible First HDHP** Group # 950201
PRESCRIPTION DRUGS			
Generic or Tier 1	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply after deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	**Tier 3** - $60 copay up to 30 day supply after deductible **Tier 4 (Specialty Drug)** - 20% coinsurance ($100 per prescription maximum) up to 30 day supply after deductible	$50 copay up to 30 day supply after deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply after deductible	$20 copay up to 100 day supply after deductible	$20 copay up to 90 day supply after deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply after deductible	$60 copay up to 100 day supply after deductible	$60 copay up to 90 day supply after deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply after deductible	$120 copay up to 100 day supply after deductible	$100 copay up to 90 day supply after deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

NEED HELP CHOOSING A PLAN OR UNDERSTANDING PLAN OPTIONS?

Advocating for You and With You. Navigating the complex world of health benefits can be a challenge, leaving you questioning if you have made the right choices for you and your family's best health.

CareCounsel's health advocacy program is a confidential health advocacy benefit sponsored by the County that can help you understand and effectively navigate your health benefits. This service is available to County employees, retirees and their family members who are enrolled in County sponsored medical, dental and/or vision plans.

CareCounsel offers high touch and customized service backed by experience and depth. Here are just a few of the things CareCounsel can help you with:

- Choosing a health plan during Annual Enrollment
- Benefits education and assistance for all types of health plans
- Getting the most of your healthcare dollars
- Helping you find physicians and get care

- Obtaining second opinions
- Troubleshooting medical claims/bills
- Grievances and appeals
- Navigating Medicare (when you turn 65 and ongoing)
- Helping you become a more proactive health consumer
- Access to the Stanford Health Library
- Stanford educational webinars and community education sessions
- Connecting you with expert healthcare resources

You can reach CareCounsel at (888) 227-3334 or via email at staff@carecounsel.com. Member Care Specialists are available 6:30 a.m. to 5:00 p.m. PST Monday - Friday. CareCounsel is a wholly owned subsidiary of Stanford Health Care.

CUSOMER SERVICE SUPPORT

Visit the insurance company websites for additional resources. Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage, and Annual Enrollment Period.

E-mail: Benefits@Sonoma-County.org
Phone: (707) 565-2900
Internet: http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/

Please note: Staffing resources are limited. When calling, leave one clear message rather than multiple messages. Your call will be returned as soon as possible. Please do not call to confirm receipt of your election. Print a copy of your election as proof of completion.

PLAN CONTACT INFORMATION

Contact your health plan carriers with questions related to your benefits coverage, to find network providers, preauthorize care as required, and confirm your residence is within the plans' service areas.

Plan	Phone	Website
County Health Plans (PPO & EPO) *Administered by Anthem Blue Cross* **Summary of Benefits and Coverage (SBC)**	(800) 759-3030	www.anthem.com/ca http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
CVS/Caremark *County Health Plans' prescription drug provider*	(800) 966-5772	www.caremark.com
Kaiser Permanente Plans **Summary of Benefits and Coverage (SBC)**	(800) 464-4000	www.my.kp.org/sonomacounty www.kp.org http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Sutter Health Plus HMO **Summary of Benefits and Coverage (SBC)**	(855) 315-5800	www.sutterhealthplus.org/sonoma-county http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Western Health Advantage HMO **Summary of Benefits and Coverage (SBC)**	(888) 563-2250	www.westernhealth.com/mywha/welcome-to-wha/county-of-sonoma http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Delta Dental Plan Group # 3126	(800) 765-6003	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
The Hartford	(888) 563-1124	www.thehartford.com
County Wellness Program	(707) 565-2900	http://sonomacounty.ca.gov/HR/Benefits/Healthy-Habits/
Sonoma County HIPAA Privacy Practices	(707) 565-4999	http://hr.sonoma-county.org/content.aspx?sid=1024&id=1225